consisting of stavudine, lamivudine, and efavirenz, was started 14 days after initiation of antimycobacterial therapy. The skin lesions resolved completely.

Seven weeks later he was readmitted with fever. Examination was unremarkable. Investigations showed total white count 18.2 × 10^9/l, with monocytes 15.2 × 10^9/l; CD4 count 70 cells × 10^6/l, and HIV viral load 10 700 copies/ml. Five days after admission new painful skin lesions appeared on his arms and legs. These were tender, erythematous, and had a pustular centre (fig 1B). The monocyte count peaked at 43.2×10^9/l on the sixth day. Aspiration of pus from a skin lesion revealed multiple AFB; MAC was subsequently cultured. Antimycobacterial therapy was intensified with addition of rifabutin, intravenous amikacin, and prednisolone (60 mg once daily reducing to zero over 14 days). The skin lesions resolved completely over 10 days as did the neutrophilia and monocytosis. Amikacin was stopped after 2 weeks. The patient remains well 8 months later.

The recurrence of disseminated MAC infection in our patient illustrates dramatically the impact of HAART on the clinical course of this disease. The highly inflammatory skin lesions that developed occurred at a higher CD4 count after HAART and differed significantly from the indolent lesions (more typical of cutaneous MAC infection in patients with advanced HIV disease) with which he originally presented. The appearances of these lesions together with the contemporaneous leukaemoid response suggest a different immunopathological process.[4 5] This case illustrates the increasingly protean manifestations of immune reconstitution disease. Clinicians caring for patients with previously documented MAC should be aware of this phenomenon if HAART is commenced.

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1 Race EM, Adelson-Mitty J, Kriegol GR, *et al*. Focal mycobacterial lymphadenopathy following initiation of protease-inhibitor therapy in patients with advanced HIV-1 disease. *Lancet* 1998;**351**:252–5.
2 Miller RF, Shaw PJ, Williams IG. Immune reconstitution CMV pneumonitis. *Sex Transm Inf* 2000;**76**:60 (letter).
3 Whitely W, Tariq A, Peters B, *et al*. Pyrexia of undetermined origin in the era of HAART. *Sex Transm Inf* 2000;**76**:484–8.
4 Cinti SK, Kaul Dr, Sax PE, *et al*. Recurrence of Mycobacterium avium infection in patients receiving highly active antiretroviral therapy and antimycobacterial agents. *Clin Infect Dis* 2000;**30**:511–4.
5 Havlir DV, Schrier RD, Torriani FJ, *et al*. Effect of potent antiretroviral therapy on immune responses to Mycobacterium avium in human immunodeficiency virus-infected subjects. *J Infect Dis* 2000;**182**:1658–63

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Detection or treatment: which outcome measure?

EDITOR,—The report by Rogstad *et al*[1] is a timely description of the problems associated with the management of patients diagnosed with genital chlamydial infection within and between established healthcare settings. The inappropriate or inadequate treatment, low rates of partner notification, and lack of referral to genitourinary medicine (GUM) clinic described were similar to the observations made in two recent studies. An investigation in Merseyside family planning clinics (FPC) showed that of 80 infected patients identified (n = 958) only 34% were treated within 1 month of diagnosis, 24% had no proof of treatment, and 13% never found out they were infected.[2] Similarly, a study of 112 women diagnosed with *Chlamydia trachomatis* attending FPCs showed that only 48% were known to have been treated 3 months after the test had been carried out.[3] If diagnosis does not result in immediate treatment, patients can be lost to follow up. In turn, this can result in poor rates of partner notification, an increased likelihood of further transmission, a reduction in the impact of testing on disease incidence, and an increased risk of complications. In GUM clinics, diagnosis generally results in treatment and consequently surveillance data derived from this setting, the KC60 dataset, can be used as a measure of treatment success. In contrast, the above studies suggest that a proportion of diagnoses made in primary care may not be treated. This questions the validity of using diagnosed infection as an outcome measure for evaluating sexual health intervention in primary care. It also emphasises the significant role of clinical audit in the improvement of the quality of patient management.

Ultimately the effectiveness of intervention should be measured in terms of a reduced prevalence of pelvic inflammatory disease and associated sequelae.[4] However, other more pragmatic outcome measures may need to be used. The UK NHS *C trachomatis* screening pilot is evaluating the feasibility and acceptability of opportunistic screening in primary and secondary healthcare settings in two health authorities.[5] Three of the primary outcome measures that are being evaluated are the number of positive diagnoses, the proportion of the positive diagnoses treated, and the rate of patient or provider led partner notification. In the pilot, patient management has been improved by recalling positive patients to a centralised community office staffed by GUM health advisers. Preliminary data indicate that out of 900 positive patients identified through the Wirral arm of the pilot, treatment was not confirmed for 40 (4.4%) patients. Separate studies in Liverpool are also evaluating how patient management could be enhanced by GUM health advisers working in outreach sessions in a community FPC (AMCW) and a department of obstetrics and gynaecology (T Gleave, submitted to *British Journal of Family Planning*). Results from these studies will provide further evidence to guide the development of patient management and the outcome measures that could be used to assess future intervention strategies.

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1 Rogstad KE, Davies A, Murthy SK, *et al*. The management of Chlamydia trachomatis: combined community and hospital care. *Sex Transm Inf* 2000;**76**:493–4.
2 Harvey J, Webb A, Mallinson H. Chlamydia trachomatis screening in young people in Merseyside. *Br J Fam Plann* 2000;**26**:199–201.
3 Wilkinson C, Massil H, Evans J. An interface of chlamydia testing by community family planning clinics and referral to hospital genitourinary medicine clinics. *Br J Fam Plann* 2000;**26**:206–9.
4 Simms I, Hughes G, Catchpole M. Screening for Chlamydia trachomatis. *BMJ* 1998;**317**:680–1.
5 Pimenta J, Catchpole M, Gray M, *et al*. Screening for genital chlamydial infection. *BMJ* 2000;**321**:629–31.

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Obituaries

EDITOR,—The obituaries of three physicians, Ambrose King, Eric Dunlop, and David Oriel, appeared in quick succession in your columns.

By the time I started training in venereology, as it was then called (not a bad name incidentally because it means the science of the act of love which encompasses STIs, colposcopy, HIV disease, and sexual dysfunction) at the Whitechapel Clinic of the London Hospital in 1973 Ambrose King had already left. However, the clinic still sparkled (not physically you understand) from his inspirational radiance and he was spoken of in hushed, reverential tones.

Eric Dunlop was the senior physician at that time. To a very junior doctor he was literally an awe inspiring figure. By today's standards he did not educate or teach. Rather you were well aware that he had laid a "golden egg" and that there was a touch of colour and brilliance in his research work and lectures. I was taught basic day to day venereology by the senior charge nurses at that department. Eric Dunlop's meticulousness was legendary. We took nine specimens from each woman to screen for *Chlamydia trachomatis* (including three cervical curettings) and a cervical biopsy. The purpose built Dunlop-Jones male urethral curette was a most efficient method of obtaining chlamydial material, although its contemporaneous thalamic overstimulation did not endear it to the patients. This meticulousness transferred itself to one's own attitude to research, and many of us also aspired to achieve Eric Dunlop's larger than life persona and facility for developing newer ideas (never really worked for me!).

I later worked for David Oriel. He made advances by quietly yet relentlessly pushing away at the broad front of research and clinical medicine. He was attracted by many of the sensible, practical, therapeutic approaches of our American colleagues—for example, benzathine penicillin for syphilis, doxycycline for chlamydia, which were far from routinely practised in the United Kingdom at that time. David Oriel also insisted on each set of clinical notes being audited on a daily basis. This was in 1978, well before clinical audit became routine.

Both Eric Dunlop and David Oriel were wholly generous and encouraging to a young